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S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)5)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

Attachment A
Statement of Licensure Violations

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to implement planned interventions for a resident with known pressure ulcers, failed to identify a pressure ulcer until it

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had progressed to a stage 2, failed to perform weekly skin assessments, and failed to identify a resident with incontince and mobility limitations as a high risk for pressure ulcer and implement interventions for prevention of pressure ulcer. These failures resulted with a resident identified at low risk for pressure ulcers to develop a Stage 3 pressure ulcer.

This applies to 3 of 5 residents (R3,R10, R11) reviewed for pressure ulcers in the sample of 15.

The findings include:

1. The May physician order sheet (POS) for R11 documents she was admitted to the facility on March 22, 2016 following a fall at home resulting in fractured cervical vertebrae. The admission Minimum Data Set (MDS) assessment of March 29, 2016 shows R11 requires extensive assist with two staff for bed mobility and transfer from bed to chair and standing. The Bladder and Bowel assessment for the MDS documents R11 to be frequently incontinent of urine. The March 22, 2016 and the March 29, 2016 Braden scale for predicting pressure sore risk showed R11 to have a score of 20 and 17, a mild risk for acquiring a pressure ulcer. No further weekly Braden assessments were documented.
The interim care plan for R11 dated March 22, 2016 documents a potential alteration in skin condition and required skin monitoring and to report red/discolored or broken skin, and turn and reposition every two hours and as needed. The March 22, 2016 admission body audit performed by admission nurse documents R11 had no skin breakdown or open areas.
On May 5, 2016 at 3:45 PM, E8 Licensed Practical Nurse (LPN), stated R11 required two assist when she was admitted. E8 said R11 was

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difficult to keep dry and always seems to have wet incontinence briefs. On May 6, 2016 at 1:00 PM, E9 LPN, stated when R11 was admitted she was unable to move herself in bed and she was always incontinent of urine, she just had no control.
The March 22, 2016 admission nursing assessment for R11 documents she required staff for assist bed mobility and to always need help to move up in bed and to sit up.
On May 5, 2016 at 3:45 PM, E8 stated R11 was a skilled resident and would have had a skin check daily by the nurse and at least twice a week by the aides during her shower. E8 stated R11 was found to have open areas on her buttocks on April 9, 2016.
On May 6, 2016 at 8:00 AM, E3 (Director of Nursing) stated any low risk resident would be one who would be able to ambulate on their own and provide their own care and would not require a daily check. E3 stated any resident who is unable to reposition and is incontinent of urine would be considered a high risk for skin breakdown or pressure ulcers. E3 stated any wound should be identified as redness or bruising before it would open and become a Stage 2 or 3.
On May 6, 2016 at 8:10 AM, E4 MDS Coordinator / Registered Nurse (RN), stated she had assessed the wounds on April 10, 2016 and the coccyx was open but would not say the wound was a stage3 but more of a stage 2. E4 stated she should have re-assessed the Braden scale risk assessment weekly after her admission. E4 stated when the wounds were found, R11 was then put on a turn and reposition schedule, but she should have been on a turn schedule prior to the wounds.
On April 9, 2016 the nurse's notes showed R11 to have a slit type open area between the buttocks. The wound documentation progress sheet

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documents the wound to be 1.2 cm x 0.3 cm (centimeters, length by width). No staging of the wound is documented. A second wound is documented as two irregular shaped areas on the right buttock. No wound measurements or staging is documented. On April 11, 2016 a fax request was sent to the physician's office for a referral to the wound clinic for two open areas at a Stage 2. The physician responded he wound assess the wounds on April 13, 2016.
The April 13, 2016 physician visit dictation notes R11 had complained of some buttock pain but makes no assessment of buttock wounds. The physician order sheet for March 2016 shows an order was written on April 13, 2016 for the wound nurse to evaluate bottom and treat.
The April 14, 2016 wound nurse assessment documents R11 to have two stage 3 pressure ulcers. The wound on the coccyx measure 2.0cm x 0.7cm. And the left buttock wound measure 4.5cm x 1.1cm.
On May 6, 2016 at 8:15 AM, E3 stated R11 was working with physical therapy when she was admitted and was very weak. E3 said R11 would refuse to get up and would always want to stay in her room. E3 said the wounds were not open when they were identified but had progressed to stage 3 over the 5 day period.
On May 6, 2016 at 3:15 PM, Z2 (RN) stated she represents Dr. Woods and would respond on his behalf. Z2 stated any resident with incontinence and mobility issues should be considered a high risk for pressure ulcers. And Z2 agreed that with appropriate interventions the wounds could have been avoidable.

2. The March 15, 2016 MDS documents R10 requires extensive assist with 2 staff for bed mobility and is totally dependent upon staff for transferring in and out of bed. The MDS showed

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R10 to be frequently incontinent of urine. The Braden scale shows R10 to be at a high risk for pressure ulcers. The March 2016 treatment record showed R10 was to have a weekly skin check performed by the nurse on Thursday evening. The record showed no skin check was documented for March 24 or the 31st.
R10's nurse's notes for March 29, 2016 document a newly identified wound on the left lower buttock. The wound measured 3.5 cm x 4 cm x 0.5cm. The notes show barrier cream was applied to the sore. The nurse's note for March 30, 2016 documents an open area on the left buttock and is a dime size bruise. No measurements or description of the wound bed or tissues is documented. The March 31, 2016 nurses note documents R10 had a stage 2 pressure ulcer on her left buttock and measured 3cm x 2 cm with drainage. The weekly wound documentation was initiated on March 31, 2016 with the wound as a stage 2.
On May 6, 2016 at 10:30 AM, the left buttock wound was observed to be a small open area with pink skin around the wound. No drainage noted, and no odor. E9 noted a new open area on R10's coccyx. E9 stated it was a new area since she had no current treatment orders for this wound. E9 measured the wound as an open stage 2 wound 0.5cm x 0.5 cm. E9 stated this area has opened and closed before and now it has re-opened. E17 Certified Nursing Assistant (CNA) stated she had been putting barrier cream on R10's bottom and she should be turned every 2 hours.
On May 6, 2016 at 8:30 AM, E3 stated the buttock was more of a pink area and it was not opened and cannot believe in one day the area opened and had drainage. E3 stated she cannot say the nursing documentation was incorrect. E3 stated the nurse with the initial documentation did

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not complete a weekly wound sheet as required per protocol.
The facility policy for Prevention and Treatment of Skin Breakdown documents the facility's policy is to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity ad pressure ulcers; to implement preventative measures. Procedure: Prevention of Pressure Ulcers 1. Braden scale will be done upon admission and weekly for the first 4 weeks post admission. 2. Monitoring of skin integrity: b. Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse in conjunction with the nursing assistant. If there is development of a pressure ulcer the following procedure is to be implemented: 10. Initiate weekly wound documentation progress sheet which will include: type of wound, location, date, stage (pressure ulcer only), length, width and depth.

3. March 1, 2016 MDS shows R3's admission date to be February 22, 2016. The same MDS shows R3 to have a diagnosis to include psychotic disorder with delusions, anxiety, diabetes, and history of cerebral vascular accident (CVA). The April 15, 2016 nursing progress notes shows R3 had a open area on his left and right inner buttocks. On April 16, 2016 a blister on his right heel measuring 10 cm (centimeters) was discovered and categorized as unstageable.

On May 5, 2016 at 9:00 AM R3 was restless and getting up as soon as the CNA, assisted him in sitting. E16 (LPN) said he (R3) has a stage 2 pressure ulcer on either side of his buttocks. On the same date and time R3 was seen leaning over in his wheelchair and leaning forward, putting pressure on his arms in an effort to relieve

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pressure off his bottom. On May 3, 2016 at 2:00 PM, E16 LPN applied barrier cream to a stage 2 pressure ulcer that measured approximately 8cm X 3cm on the right side of the buttocks and 5cm X 4cm on the left side of the buttocks. No visible drainage was seen. R3 had a 4cm in diameter blister on his right heel. On May 3, 2016 at 3:30 PM while in bed R3's heels were not being floated. On May 4, 2016 at 9:21 AM R3's heels were not being floated. On May 5, 2016 at 8:15 AM R3 was in bed with heels not floated. On May 4, 2016 at 12:24 PM, E3 said, if R3's Physician's orders say to float R3's heels while in bed, then it should be done. On May 4, 2016 at 9:30 AM R3 was in his wheelchair without his seat cushion. On May 4, 2016 at 12:24 PM, E3 DON said, his (R3) seat cushion not being on his wheelchair was my fault. I transferred R3 into the wheelchair and forgot to put the cushion on.

On May 3, 2016 at 9:00 AM R3 said my butt hurts if I sit on it. On May 4, 2016 at 1:48 PM R3 stated, "did you know about my back side? My butt really hurts, I have a sore." On May 5, 2016 at 9:14 AM R3 said my butt hurts. On May 4, 2016 at 10:00 AM, E11 RN said she did not assess R3's pain yet and did not give any medication for pain. On May 5, 2016 at 10:00 AM E18 CNA said she did not realize that R3's heels should be floated while in bed. We get information on resident's care in daily report and on communication sheets and floating heels was not on my communication sheet. On May 4, 2016 at 12:24 PM E3 said we are trying to make positive changes in the way information is being passed down to the CNA's after there is a change in care for the residents. On the same date and time E3 said that a pain assessment should be done upon admission and when there is a change in the resident's condition. E3 said a pressure ulcer is a change in

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condition. R3 had one pain assessment sheet in his chart dated February 2, 2016, but none after that. E3 said weekly wound reports should be completed weekly. R3's buttocks wound was assessed on April 15, 2016 with no other weekly wound reports completed. R3's right heel wound was assessed on April 16, and April 23, 2016 with no other wound reports completed.

The June 15, 2012 prevention and treatment of skin breakdown policy and procedure shows when there is a development of a new pressure ulcer the following procedures will be implemented; #5 notify therapy department for seating surface evaluation and possible treatment interventions in other interdisciplinary team members as appropriate. #7 initiate Braden Scale form. #9 update nursing assistant profiles with skin concerns, appropriate risk factors, turning intervals and interventions as appropriate. #11 when a pressure ulcer is present, daily wound monitoring should include; A. An evaluation of the ulcer. E. whether pain is being adequately controlled. The April, 2016 POS shows on April 16, 2016 to float heels in bed and monitor every shift. The TAR (treatment administration record) for May, 2016 shows that heels are to be elevated in bed with no documentation for first shift on the 2, 3, 4, and 5 of May.

(B)